



Optometric and Eyeglass Services

Provided by:

*Ophthalmologists, Optometrists,
Opticians and Eyeglass Providers*

*Medicaid, CHIP and Other Medical
Assistance Programs*



April 2006

This publication supersedes all previous Optometric and Eyeglass Services provider handbooks. Published by the Montana Department of Public Health & Human Services, March 2003.

Updated July 2003, April 2004, January 2005, April 2005, August 2005, October 2005, April 2006.

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My Medicaid Provider ID Number:
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My CHIP Provider ID Number:

descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Retroactive Eligibility

Medicaid does not cover eyeglasses for clients who become retroactively eligible for Medicaid when the eyeglasses were purchased before retroactive eligibility was determined. However, Medicaid does cover eye exams for retroactively eligible clients. For example, suppose that a client had an eye exam and purchased eyeglasses on July 15. On September 1, the Department determined the client was eligible for Medicaid retroactive to July 1. Medicaid would pay for the eye exam but not for the eyeglasses.

Coverage of Specific Services

The following are coverage rules for specific services provided by optometrists, opticians, and ophthalmologists. Due to limits on exams and eyeglasses, before providing these services, the provider should contact Provider Relations (see *Key Contacts*) to verify the client is currently eligible for an exam, and contact the eyeglass contractor (see *Key Contacts*) to verify the client is eligible for eyeglasses. Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor (see *Key Contacts*). All services are subject to post payment review and payment recovery if they are not medically necessary (see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual).

Contact lenses

Contact lenses are covered only when medically necessary and not for cosmetic reasons. Dispensing providers must obtain prior authorization for all contact lenses and dispensing fees (see the *Prior Authorization* chapter in this manual). The same limits that apply to eyeglasses and repairs also apply to contacts. Contact lenses are not provided by the eyeglass contractor and therefore may be provided by other providers. Medicaid covers them when the client has one the following conditions:

- Keratoconus
- Sight that cannot be corrected to 20/40 with eyeglasses
- Aphakia
- Anisometropia of 2 diopters or more



Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor



If a provider does not check client eligibility prior to an exam, and the claim is denied because the client's exam limit was exceeded, the provider cannot bill Medicaid or the client.

Adults (age 21 and older) are limited to one eye exam and one pair of eyeglasses every 730 days. Children (ages 20 and under) are limited to one eye exam and one pair of eyeglasses every 365 days.

Eye exams

Before providing an eye exam, verify that the client is eligible for an exam by contacting Provider Relations (see *Key Contacts*). Medicaid clients ages 21 and over are limited to one eye examination for determining refractive state every 730 days. Medicaid clients ages 20 and under are limited to one eye examination for determining refractive state every 365 days. The Department allows exceptions to these limits when one of the following conditions exists:

- Following cataract surgery, when more than one exam during the respective period is necessary
- A screening shows a loss of one line acuity with present eyeglasses
- Adult diabetic clients may have exams every 365 days

Eyeglass services

Before providing eyeglasses to a client, verify that the client is eligible by contacting the eyeglass contractor (see *Key Contacts*). Adults ages 21 and older are eligible for eyeglasses every 730 days. If the client has a diagnosed medical condition that prohibits the use of bifocals, Medicaid may cover two pairs of single vision eyeglasses every 730 days. Although prior authorization is not required, the provider must document the client's inability to use bifocals. Children ages 20 and under are eligible for eyeglasses every 365 days. If one of the following circumstances exists within the respective time limits, lenses only will be replaced:

- .50 diopter change in correction in sphere
- .75 diopter change in cylinder
- .5 prism diopter change in vertical prism
- .50 diopter change in the near reading power
- A minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters
- A minimum of a 3 degree change in axis of any cylinder greater than 3.00 diopters
- Any 1 prism diopter or more change in lateral prism

If any one of these changes is in one eye, Medicaid will cover that lens only. Medicaid will not cover a new frame at the time of a prescription change within the respective time limits.

Eyeglasses are covered for an initial/new prescription when the client has at least one of the following circumstances in one or both eyes:

- Cataract surgery
- .50 diopter correction in sphere
- .75 diopter correction in cylinder
- .5 prism diopter correction in vertical prism

- .50 diopter correction in near reading power
- Any 1 prism diopter or more correction in lateral prism

Frame services

The eyeglass contractor will provide a list of Medicaid-covered frames to dispensing providers.

Medicaid clients have the option of using their “existing frames” and Medicaid will cover lenses. The existing frame is a frame that the client owns or purchases. When a client chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the client), Medicaid will pay for a contract frame but not new lenses. The client can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.

Lens add-ons

Medicaid covers some “add-on” or special features for eyeglass lenses, and some are available on a private pay basis (see following table).

Lens Add-Ons			
Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Medicaid Contract Rate Per Lens
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary	No	\$18.50
Photochromic - Glass (i.e. photogray, photo-brown)	Yes - if medically necessary	No	\$4.50
Progressive	No, but Medicaid will pay \$21.00 and client must pay balance	No, but Medicaid will pay \$21.00 and client must pay balance	VIP \$30.50 XL \$30.50 Percepta \$34.00 Comfort \$35.50
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes - if client is monocular	Yes - if client is monocular	\$4.00
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	Yes	No charge

Lens Add-Ons (continued)

Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Medicaid Contract Rate Per Lens
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary	No	\$1.25
UV and scratch-resistant coatings	Yes - if medically necessary	No	\$1.50
Slab-off and fresnell prism	Yes - if medically necessary	Yes - if medically necessary	No charge

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this manual will be billed to the dispensing provider at the eyeglass contractor's normal and customary charges. The Department requests that providers bill clients the Walman Medicaid rate for scratch guard and polycarbonate lenses. For other add-ons noted above that are not covered by Medicaid, payment is a private arrangement between the client and the provider. This means that the provider may charge either the usual private pay rate or the Walman Medicaid rate to the client.

Lens styles and materials

All eyeglass lenses fabricated by the eyeglass contractor for Medicaid clients must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

Medicaid covers the following lens styles:

- Single vision
- Flattop segments 25, 28, 35
- Round 22
- Flattop trifocals 7 x 25, 7 x 28
- Executive style bifocals.

Medicaid covers the following lens materials (no high index):

- Glass
- CR-39
- Polycarbonate for monocular clients only. Medicaid clients who are not monocular can choose polycarbonate lenses and pay the difference as an add-on (see previous table of *Lens Add-Ons*).

ment fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. You do not need to use modifiers for left and right, and do not bill on separate lines. For example, a bilateral close tear duct opening procedure would be billed like this:
- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).

24.	A						B	C	D			E	F		G	H	I	J	K
	DATE(S) OF SERVICE To						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY													
1	02	23	03	02	23	03	11		68761 50			1	250.00		1				

Billing Tips for Specific Services

Bundled services

Certain services with CPT-4 or HCPCS codes (eg., tear duct plugs) are covered by Medicaid but have a fee of zero. This means that the service is typically “bundled” with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Contact lenses

When billing Medicaid for contact lenses, include the prior authorization number on the claim (field 23 of the CMS-1500 form).

Eye exams

- A client may be eligible for an eye exam before the specified time limit expires if he or she meets the criteria described in the *Covered Services* chapter, *Eye exams* section of this manual. In this case, enter the reason for the exam on the claim (box 19 of the CMS-1500 claim form).
- Medicare does not cover eye refraction (92015) but instructs providers to report this service as a separate line item from the other service(s) per-

formed. Medicaid covers this procedure, so providers can bill for the eye exam and the refraction.

- Children (age 20 and under for Medicaid or 18 and under for CHIP) may receive an additional exam before the 365-day limit has passed if they have had at least a one line acuity change resulting in prescribing replacement lenses that meet the criteria in the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for the exam using EPSDT indicator 1 on the claim (field 24h on the CMS-2500 form). See the *Completing a Claim* chapter in this manual.

Eyeglass services

- Adult clients (ages 21 and older) may receive new lenses before the 730-day limit has passed if they meet the criteria described the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens(es) using modifiers 52 and U4 with the dispensing fee procedure code. Adult recipients may be eligible for replacement lenses 12 months after the initial dispensing of contract eyeglasses *if* the lenses are broken or unusable.
- Children (age 20 and under for Medicaid or 18 and under for CHIP) may receive new lenses before the 365-day limit has passed if they meet the criteria in the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens(es) using EPSDT indicator 1 on the claim (field 24H of the CMS-1500 claim form).
- If the adult Medicaid client (age 21 and over) is not eligible for lens(es) and/or frame within the 730-day period (see *Covered Services* chapter, *Eyeglass services*) the dispensing provider may not bill Medicaid for a dispensing fee. If the client chooses to purchase eyeglasses privately, the provider may bill the Medicaid client for dispensing services and eyeglass materials.
- The eyeglass contractor will bill Medicaid for the laboratory and material costs for lenses and frames.
- Please bill CHIP for eyeglass services and BlueCHIP for optometric services.

Frame services

- When the Medicaid client uses an existing frame, the dispensing provider bills Medicaid for dispensing services, lenses only.
- Providers may not charge a dispensing fee for minor frame repairs that they provide themselves.
- If a client that is covered by Medicare and Medicaid chooses a frame outside the Medicaid contract, the provider cannot bill Medicaid for the dispensing fee. All charges must be billed to Medicare and the client.